Kiddie West Pediatric Center
4766 W. Broad Street
Columbus, OH 43228
614-851-7337

Young Adult Questionnaire
For Young Adults - Age 18+

Patient Name	Date of Birth	Age

MEDICAL HISTORY UPDATE

Any major illnesses?…… ..... Y N
If yes, explain: _____

Any major injuries (fractures, concussions, head injuries) ……. ..... Y N
If yes, explain: _____

Any hospitalizations?……..... Y N
If yes, explain: _____

Any surgeries?……..... Y N
If yes, explain: _____

PAST / PRESENT HEALTH CONCERNS (General Health)

Are you any concerns or complaints regarding any of these? *(Circle all that apply)*

Sleep problems - How many hours of sleep do you get? _____	Allergy or nasal symptoms	Acme	Stomach ache / heartburn	Bruising or bleeding easily
Appetite / weight	Wheezing or cough	Rashes	Urinary symptoms	Joint pain or dislocations
Energy	Shortness of breath	Diarrhea	Headaches	Injuries (fractures, sprains, tears)
Anxiety	Chest pain	Constipation	Fainting / blackouts / dizzy	Exercise problems
Depression			Head injury / Concussion	Vision or hearing

SCHOOL AND WORK

SCHOOL

Do you attend school? _____Yes ____ No. If yes, where: _____
Where do you live? ____ Dorm / Frat _____ Apt or house _____ With Parents

WORK

Do you have a job? _____Yes ____ No. If yes, what type of work? _____

NUTRITION / EXERCISE

Do you have special dietary restrictions? _____Yes ____ No. If yes, what are they? _____
Do you play a sport or exercise regularly? _____Yes ____ No. If yes, what do you do? _____

Parent / Guardian Signature and Date	Provider Signature and Date

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FAMILY

Have any of the following *recently happened* to you or a member of your immediate family?
(Check off any that apply)

__Marriage __Divorce __Given birth __Moved to a new home
__Death __Loss of Job __Moved away from home

ALCOHOL / DRUGS / TOBACCO

ALCOOL USE (CRAFFT)

Have you ever ridden in a **Car** driven by someone (including yourself) who was high or had been using alcohol or drugs?..... Y N
Do you ever use alcohol or drugs to **Relax**, feel better about yourself, or fit in? ..... Y N
Do you ever use alcohol or drugs while you are by yourself **Alone**?..... Y N
Do you ever **Forget** things you did while using alcohol or drugs? ..... Y N
Do your **Family** or **Friends** ever tell you that you should cut down on your drinking or drug use?..... Y N
Have you ever gotten into **Trouble** while you were using alcohol or drugs? ..... Y N

DRUG USE

Have you used any of these drugs? (Check off any that apply)

___No Doz ___Sleeping Pills ___Pain Pills ___Laxatives ___Water pills ___Diet pills
___Marijuana ___Speed ___Cocaine ___Mushrooms ___Ecstasy ___Steroids
___Methamphetamines (Meth) ___Other How often are you currently using these drugs? _____

TOBACCO USE

Do you chew or smoke tobacco?..... Y N
If yes, how often? _____
When did you start? _____
Would you like information on how to quit?..... Y N

SAFETY

Do you wear your seat belt when driving or riding every time?..... Y N
Do you text or talk on your cell phone while driving?..... Y N
Have you ever had a speeding ticket? ..... Y N
Do you always wear a helmet? ..... Y N
(biking, rollerblading/skating, skate/snowboarding, scooter, or motorcycle)
Do you have a gun? ..... Y N
If yes, is it locked?

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SEXUALITY

Are you or have you ever been sexually active? ……... Y N
If yes, what type? _____oral _____vaginal intercourse _____anal intercourse
Have you ever had any STD's? ……..... Y N
Have you ever been in an abusive relationship? …… ... Y N
Do you have any questions about sexuality or sexual preference……..... Y N

EMOTIONAL HEALTH (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle the best answer	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in someway	0	1	2	3
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? [] Not difficult at all [] Somewhat difficult [] Very difficult [] Extremely difficult				

Gad-7

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle the best answer)	**Not at all**	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

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FOR WOMEN ONLY

How many days between periods? _____ days
Do you ever miss periods?……..... Y N
Date of your last period: _____
Are there any symptoms with your period that concern you? ……..... Y N
If yes, what? _____
Have you ever been pregnant? …… ..... Y N
Have you ever had an abortion? ……..... Y N

CONTACT INFORMATION

Contact numbers:

Home: _____ Work: _____

Cell: _____

In case of an emergency, whom should we call?

Name: _____ Phone: _____

If necessary may we contact your parents? ……..... Y N
If yes, where? Phone _____

Parent / Guardian Signature and Date	Provider Signature and Date